Delphi stock

Our Basis for Objection listed as "equity Claim" should not be disallowed or stayed.

We did not hold our stock solely because its holdings

We were and still forced To hold on To our holdings

When I had The stock my wife was forced to give up her job To Take care of me.

We still had Three children at home and one in college

We were forced to save every penny we could.

I was forced To use our dividend checks for

employed. which we still
have to do Today.

If it would have sold
the stock Then the next
year I would have had
less money

We had To do without
the things most people
had or have. We still
have to do it Today

No cable or satellite T. V.,
computers, Cell Ph's. and
the nice things that
people have or do.

Then when I had the
stroke it kept getting
Pneumonia and the Doctors
at the Medical Center in
Ann Arbor and the

Cleveland Clinic told me to get out of the cold winters here in Michigan — we didn't have any place to go.

When my brother who was retired in Florida heard about it. He told us to come down with them which we did for about 2 yrs.

Then we found a cheap small house which we bought.

While we were in Florida during the winters Doctors there told me to get out of the heat in the summers there.

We have been through hell and still going through it.

My wife "Darla" now also has heart trouble

I have been to the government for help but no luck.

We owe so much to our children for all the things they have done for us.

I worked extremely hard for what I have and feel like I'm being cheated out of it.

Edwin L. Schmidt
Darla J. Schmidt

Form **1040** Department of the Treasury - Internal Revenue Service **U.S. Individual Income Tax Return 2006** (99) IRS Use Only - Do not write or staple in this space.

For the year Jan. 1-Dec. 31, 2006, or other tax year beginning , 2006, ending , 20 OMB No. 1545-0074

Label (See instructions on page 16.) **Use the IRS label.** Otherwise, please print or type.

Your first name and initial: ALVIN C.	Last name: SCHMIDT
If a joint return, spouse's first name and initial: DARLA J.	Last name: SCHMIDT TAXPAYER COPY
Home address (number and street). If you have a P.O. box, see page 16.: 9650 LANGAN ST.	Apt. no.
City, town or post office, state, and ZIP code. If you have a foreign address, see page 16.: SPRINGHILL FL 34606	

Your social security number: 383-30-6301
Spouse's social security number: 371-32-8579
☐ You must enter your SSN(s) above. ☐

Checking a box below will not change your tax or refund.

Presidential Election Campaign ▶ Check here if you, or your spouse if filing jointly, want $3 to go to this fund (see page 16) ▶ ☐ You ☐ Spouse

Filing Status Check only one box.

1 ☐ Single
2 ☒ Married filing jointly (even if only one had income)
3 ☐ Married filing separately. Enter spouse's SSN above and full name here. ▶
4 ☐ Head of household (with qualifying person). (See page 17.) If the qualifying person is a child but not your dependent, enter this child's name here. ▶
5 ☐ Qualifying widow(er) with dependent child (see page 17)

Exemptions

6a ☒ **Yourself.** If someone can claim you as a dependent, **do not** check box 6a
b ☒ **Spouse**
Boxes checked on 6a and 6b: 2

c **Dependents:**

(1) First name Last name	(2) Dependent's social security number	(3) Dependent's relationship to you	(4) ✓ if qual. child for child tax cr. (see page 19)

If more than four dependents, see page 19.

No. of children on 6c who:
- lived with you
- did not live with you due to divorce or separation (see page 20)

Dependents on 6c not entered above
Add numbers on lines above ▶: 2

d Total number of exemptions claimed: 2

Income

Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.

If you did not get a W-2, see page 23.

Enclose, but do not attach, any payment. Also, please use Form 1040-V.

7	Wages, salaries, tips, etc. Attach Form(s) W-2			7	
8a	**Taxable** interest. Attach Schedule B if required			8a	4,329
b	**Tax-exempt** interest. **Do not** include on line 8a	8b			
9a	Ordinary dividends. Attach Schedule B if required			9a	2,743
b	Qualified dividends (see page 23)	9b	2,442		
10	Taxable refunds, credits, or offsets of state and local income taxes (see page 24)			10	
11	Alimony received			11	
12	Business income or (loss). Attach Schedule C or C-EZ			12	
13	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶ ☒			13	599
14	Other gains or (losses). Attach Form 4797			14	
15a	IRA distributions	15a	8,404	b Taxable amount (see page 25) 15b	8,404
16a	Pensions and annuities	16a	17,127	b Taxable amount (see page 26) 16b	16,213
17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E			17	-5,824
18	Farm income or (loss). Attach Schedule F			18	
19	Unemployment compensation			19	
20a	Social security benefits	20a	20,292	b Taxable amount (see page 27) 20b	2,305
21	Other income. List type and amount (see page 29)			21	
22	Add the amounts in the far right column for lines 7 through 21. This is your **total income** ▶			22	28,769

Adjusted Gross Income

23	Archer MSA deduction. Attach Form 8853	23		
24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24		
25	Health savings account deduction. Attach Form 8889	25		
26	Moving expenses. Attach Form 3903	26		
27	One-half of self-employment tax. Attach Schedule SE	27		
28	Self-employed SEP, SIMPLE, and qualified plans	28		
29	Self-employed health insurance deduction (see page 29)	29		
30	Penalty on early withdrawal of savings	30		
31a	Alimony paid b Recipient's SSN ▶	31a		
32	IRA deduction (see page 31)	32		
33	Student loan interest deduction (see page 33)	33		
34	Jury duty pay you gave to your employer	34		
35	Domestic production activities deduction. Attach Form 8903	35		
36	Add lines 23 through 31a and 32 through 35		36	
37	Subtract line 36 from line 22. This is your **adjusted gross income** ▶		37	28,769

A
THIS WAS OUR TOTAL INCOME THE REASON FOR THIS AMOUNT IS I RECEIVED AN INHERITANCE FROM MY SISTER

SOCIAL SECURITY ADMINISTRATION

How We Counted Your And Your Spouse's Income To Determine Your Subsidy

For January 2006 and continuing

Social Security	$13,946.40
Other Income	36,000.00
(General Income Exclusion)	(240.00)
Subtotal of Your Income We Count	**$49,706.40**
Total Income We Count	**$49,706.40**
Income Limit For Subsidy Eligibility	$19,245.00

I WROTE TO THE SOCIAL SECURITY OFFICE IN CHICAGO FOR AN ITEMIZED ACCOUNT OF THIS INCOME. NO REPLY FROM THEM

LIARS OR WHAT ?

383306301 08/04/2005 10:41 AM

Department of the Treasury - Internal Revenue Service

Form 1040 U.S. Individual Income Tax Return 2004

(99) IRS Use Only - Do not write or staple in this space.

For the year Jan. 1-Dec. 31, 2004, or other tax year beginning , 2004, ending , 20

OMB No. 1545-0074

Label (See instructions on page 16.) Use the IRS label. Otherwise, please print or type.

Your first name and initial: ALVIN C.	Last name: SCHMIDT
If a joint return, sp. first name & initial: DARLA J.	Last name: SCHMIDT
Home address (number and street). If you have a P.O. box, see page 16.: 9650 LANGAN ST.	Apt. no.
City, town or post office, state, and ZIP code. If you have a foreign address, see page 16.: SPRINGHILL FL 34606	

Your social security number: 383-30-6301

Spouse's social security number: 371-32-8579

Important! You must enter your SSN(s) above.

Presidential Election Campaign (See page 16.)

Note. Checking "Yes" will not change your tax or reduce your refund.

Do you, or your spouse if filing a joint return, want $3 to go to this fund? You: ☐ Yes ☒ No Spouse: ☐ Yes ☒ No

Filing Status Check only one box.

1 ☐ Single
2 ☒ Married filing jointly (even if only one had income)
3 ☐ Married filing separately. Enter spouse's SSN above and full name here. ▶
4 ☐ Head of household (with qualifying person). (See page 17.) If the qualifying person is a child but not your dependent, enter this child's name here. ▶
5 ☐ Qualifying widow(er) with dependent child. (See page 17.)

Exemptions

6a ☒ **Yourself.** If someone can claim you as a dependent, **do not** check box 6a — Boxes checked on 6a and 6b: 2

b ☒ **Spouse**

c **Dependents:**

(1) First name Last name	(2) Dependent's social security number	(3) Dependent's relationship to you	(4) Ck. if qual. child for child tax cr. (see pg. 18)	

If more than four dependents, see page 18.

No. of children on 6c who: ● lived with you ____ ● did not live with you due to divorce or separation (see page 18) ____

Dependents on 6c not entered above ____

d Total number of exemptions claimed — Add numbers on lines above ▶ 2

Income

Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.

If you did not get a W-2, see page 19.

Enclose, but do not attach, any payment. Also, please use Form 1040-V.

7	Wages, salaries, tips, etc. Attach Form(s) W-2		7	
8a	**Taxable** interest. Attach Schedule B if required		8a	1,340
b	**Tax-exempt** interest. **Do not** include on line 8a	8b		
9a	Ordinary dividends. Attach Schedule B if required		9a	4,695
b	Qualified dividends (see page 20)	9b 4,695		
10	Taxable refunds, credits, or offsets of state and local income taxes		10	
11	Alimony received		11	
12	Business income or (loss). Attach Schedule C or C-EZ		12	
13	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶ ☐		13	14
14	Other gains or (losses). Attach Form 4797		14	
15a	IRA distributions 15a	b Taxable amount (see page 22)	15b	3,000
16a	Pensions and annuities 16a 11,912	b Taxable amount (see page 22)	16b	11,112
17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E		17	-4,222
18	Farm income or (loss). Attach Schedule F		18	
19	Unemployment compensation		19	
20a	Social security benefits 20a 18,986	b Taxable amount (see page 24)	20b	
21	Other income. List type and amt. (see page 24)		21	
22	Add the amounts in the far right column for lines 7 through 21. This is your **total income** ▶		22	15,939

Adjusted Gross Income

23	Educator expenses (see page 26)	23		
24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24		
25	IRA deduction (see page 26)	25		
26	Student loan interest deduction (see page 28)	26		
27	Tuition and fees deduction (see page 29)	27		
28	Health savings account deduction. Attach Form 8889	28		
29	Moving expenses. Attach Form 3903	29		
30	One-half of self-employment tax. Attach Schedule SE	30		
31	Self-employed health insurance deduction (see page 30)	31		
32	Self-employed SEP, SIMPLE, and qualified plans	32		
33	Penalty on early withdrawal of savings	33		
34a	Alimony paid b Recipient's SSN ▶	34a		
35	Add lines 23 through 34a		35	
36	Subtract line 35 from line 22. This is your **adjusted gross income** ▶		36	15,939

THIS HAS BEEN ABOUT FOR THE LAST 2 YRS. OUR AVERAGE INCOME

Department of Veterans Affairs

1500 WEISS ST
SAGINAW MI 48602-5251

MCCR (003M) EXT. 3080

001176
ALVIN C SCHMIDT
1346 W DENVER RD
WEIDMAN MI 48893-9768

STATEMENT OF MEDICAL CARE COST RECOVERY ACCOUNT ACTIVI

NAME OF FACILITY
ALEDA E LUTZ VA MEDICAL CENTER (655)

FOR QUESTIONS ABOUT YOUR ACCOUNT, PLEASE PHONE THE BELOW NO.
989-497-2500 EX 3080

For written inquiries concerning your account please send them to th MCCR or Revenue Office at the facility address above. For informati regarding your rights and obligations on charges owed the United Stat Government, please refer to paragraph(s) on reverse of this statement

Payments received after 11/09/2003 will be reflected o your next statement.

PATIENT NAME: ALVIN C SCHMIDT ACCOUNT NO. 655383306301SCHMI STATEMENT DATE: 11/13/2003

TRANSACTION POSTED	DESCRIPTION	AMOUNT	BILLING REFERENCE
10/16/2003	COPAY RX:833628 FD:07/16/2003 DRUG:SPIRONOLACTONE 25MG TAB DAYS:90 QTY:90 PHY:TUNNEY,JENNIFER M CHG:$21.00	21.00	655-K400932
10/16/2003	COPAY RX:833626 FD:07/16/2003 DRUG:SIMVASTATIN 40MG TAB DAYS:90 QTY:45 PHY:TUNNEY,JENNIFER M CHG:$21.00	21.00	655-K400932
10/16/2003	COPAY RX:833625 FD:07/16/2003 DRUG:POTASSIUM CHLORIDE 10MEQ SA TAB DAYS:90 QTY:90 PHY:TUNNEY,JENNIFER M CHG:$21.00	21.00	655-K400932
10/16/2003	COPAY RX:833623 FD:07/16/2003 DRUG:METOPROLOL SUCCINATE 50MG SA TAB DAYS:90 QTY:90 PHY:TUNNEY,JENNIFER M CHG:$21.00	21.00	655-K400932
10/16/2003	COPAY RX:833622 FD:07/16/2003 DRUG:METOLAZONE 2.5MG TAB DAYS:90 QTY:24 PHY:TUNNEY,JENNIFER M CHG:$21.00	21.00	655-K400932
10/16/2003	COPAY RX:833614 FD:07/16/2003 DRUG:GLIPIZIDE 5MG TAB DAYS:90 QTY:90 PHY:TUNNEY,JENNIFER M CHG:$21.00	21.00	655-K400932
10/16/2003	COPAY RX:833611 FD:07/16/2003 DRUG:ENALAPRIL MALEATE 10MG TAB DAYS:90 QTY:180 PHY:TUNNEY,JENNIFER M CHG:$21.00	21.00	655-K400932
10/16/2003	COPAY RX:833610 FD:07/16/2003 DRUG:DIGOXIN (LANOXIN) 0.25MG TAB DAYS:90 QTY:90 PHY:TUNNEY,JENNIFER M CHG:$21.00	21.00	655-K400932
10/16/2003	COPAY RX:833609 FD:07/16/2003 DRUG:ALLOPURINOL 300MG TAB DAYS:90 QTY:90 PHY:TUNNEY,JENNIFER M CHG:$21.00	21.00	655-K400932
10/16/2003	COPAY RX:833617 FD:07/16/2003 DRUG:INSULIN NOVOLIN 70/30 (NPH/REG) INJ NOVO	21.00	655-K400932

PD. 3598 CK#

SUMMARY OF MONTHLY ACTIVITY	PREVIOUS BALANCE	TOTAL CHARGES	TOTAL CREDIT PAYMENT	CURRENT BALANCE
	15.00	217.00	15.00-	217.00

PLEASE DETACH THIS COUPON BELOW AND RETURN WITH PAYMENT DO NOT INCLUDE ANY CORRESPONDENCE WITH PAYMENT

ACCORDING TO THIS I WAS (HAD) PAID FOR ALMOST 10 OTHER PEOPLE

medcohealth
P.O. Box 736, Pine Brook, New Jersey 07058-0736

Medco Health Solutions, Inc.

QUARTERLY SUMMARY OF BENEFITS

PA
1 c

THIS IS NOT A BILL

SCHMIDT ALVIN C
1346 WEST DENVER
WEIDMAN MI 48893

Member Number:	[redacted]6
Group Number:	GM00
Statement Date:	10/24
Summary Period:	07/01/03 TO 09/30
Provider:	G M SALARIED INTEGRA
Carrier Number:	1

If you have questions about your pharmacy benefit, please call Member Services at the toll-free phone number shown on your medical or prescription drug id card.

Date of Service	Rx Number	Drug Name	Amount Charged	Amount Allowed	Your Responsibility Cr	Your Responsibility Not Covered	Benefit Paid	Reason Codes
ALVIN								
		DEPT OF VETERANS AFFAIRS						
07/16/03	0833611	VASOTEC	2.20	2.20				
07/16/03	0833626	ZOCOR	2.20	2.20				
07/16/03	0833617	NOVOLIN 70/30	2.20	2.20				
07/16/03	0833610	LANOXIN	2.20	2.20				
07/16/03	0833623	TOPROL XL	2.20	2.20				
07/16/03	0833614	GLIPIZIDE	2.20	2.20				
07/16/03	0833628	SPIRONOLACTON	2.20	2.20				
07/16/03	0833609	ALLOPURINOL	2.20	2.20				
07/16/03	0833622	ZAROXOLYN	2.20	2.20				
07/16/03	0833625	POTASSIUM CHL	2.20	2.20				
07/30/03	0838988	COUMADIN	2.20	2.20				
08/16/03	0833611	VASOTEC	2.20	2.20				
08/16/03	0833626	ZOCOR	2.20	2.20				
08/16/03	0833617	NOVOLIN 70/30	2.20	2.20				
08/16/03	0833610	LANOXIN	2.20	2.20				
08/16/03	0833623	TOPROL XL	2.20	2.20				
08/16/03	0833614	GLIPIZIDE	2.20	2.20				
08/16/03	0833628	SPIRONOLACTON	2.20	2.20				
08/16/03	0833609	ALLOPURINOL	2.20	2.20				
08/16/03	0833625	POTASSIUM CHL	2.20	2.20				
08/16/03	0833622	METOLAZONE	2.20	2.20				
		MEDCO HEALTH LAS VEGAS						
08/29/03	3559307	LASIX	53.25	53.25				
PATIENT TOTAL			99.45	99.45				

these are generic prescriptions

0060757

Definition Of Terms

DATE OF SERVICE Date the prescription was dispensed at your pharmacy.

COPAYMENT The portion of the amount charged which you are responsible.

[illegible] The portion of the amount charged

Social Security Administration
Medicare Prescription Drug Assistance
Receipt of Application

Wilkes-Barre Data Operations Center
PO Box 1020
Wilkes-Barre, PA 18767-1020
Date: October 2, 2005
Social Security Number: 383-30-6301

1M1PCW0009772 0.450 AB 0.301 T00000236

ALVIN SCHMIDT
1346 W DENVER RD
WEIDMAN MI 48893-9768

This is a Receipt for Your Application for Help With Medicare Prescription Drug Plan Costs

We received your Application for Help with Medicare Prescription Drug Plan Costs and will process it as quickly as possible. We will contact you if we need more information.

I did not apply for help with the Medicare Prescription Plan Costs. what I told them on the card was that I couldn't afford any of the Goverments help. I need what little they pay me in my Social Security so my wife can eat.

Oct. 7-05

Alvin L. Schmidt
Darla J. Schmidt

MEMORANDUM
State of Michigan

DISABILITY DETERMINATION SERVICE

For
SOCIAL SECURITY CLAIMS
P.O. Box 1200, Traverse City, Michigan 49685

REQUEST FOR WORK HISTORY FORM

Alvin Schmidt
1346 W. Denver
Weidman, MI 48893

Date: September 23, 1982
A/N: 383-30-6301
District: 3-MFB:mco

Our agency will make the disability determination on your Social Security and/or Supplemental Security Income claim for disability benefits. To process your claim, we need detailed information about your work history. We are interested in what you did, how heavy the work was, what tools or machines you used and what skills were required.

We will have all the information we need if you complete the attached form. Write down your most recent job first, and include all jobs you have held for more than 12 months DURING THE LAST 15 YEARS. If you need more space, use Part III of the form (last page). IT IS MOST IMPORTANT THAT YOU FILL OUT THIS FORM AS COMPLETELY AS YOU POSSIBLY CAN. Please PRINT your answers clearly, and RETURN this form to us WITHIN SEVEN DAYS. If you do not return this form, or do not complete it as requested, your claim will be delayed. If you have questions, call toll free 1-800-632-1097 ext. 45.

THIS IS THE FIRST LETTER I GOT FROM SOCIAL SECURITY I WAS RULED AT FIRST BEING DISABLED OCT. 16, 1981

Enclosure

DDS-143
a31

THESE ARE THE FIGURES THEY BASED MY SOCIAL SECURITY ON. ALSO MY WIFE S.S. PAYMENT IS BASED ON MY DISABILITY

MSG-Z016436 DTE-07/08/87 SEQY QN-383-30-6301 ID-SCHMI UN-RMR PG-001+
MEF: QN: 383-30-6301 NA: A C SCHMID DB: 07/30 SX: M AK:
SUMMARY FICA EARNINGS FOR YEARS REQUESTED
614.73 EARNED 37-50/YEARLY EARNINGS AMOUNTS NOT AVAILABLE

YR	EARNINGS	YR	EARNINGS	YR	EARNINGS	YR	EARNINGS
57	919.87	64	1492.80	71	7800.00	77	16500.00
58	525.97	65	3281.77	72	9000.00	78	17700.00
59	466.63	66	6600.00	73	10800.00	79	22900.00
60	1306.02	67	6600.00	74	13200.00	80	22018.91
61	1159.82	68	7800.00	75	14100.00	81	29700.00
62	1399.73	69	7800.00	76	15300.00	82	26674.28

MSG-Z016436 DTE-07/08/87 SEQY QN-383-30-6301 ID-SCHMI UN-RMR PG-002

63	1387.02	70	7800.00

SUMMARY MQGE EARNINGS FOR YEARS REQUESTED
NO MQGE EARNINGS FOR YEARS REQUESTED
REMARKS
CLAIMS ACTIVITY -- SEE MBR
W-2 PENSION EARNINGS PRESENT FOR: 1985
NON-COVERED EARNINGS PRESENT FOR: 1981,1984-1986

Copy mailed to

EBRAS - TR-25

General Motors Corporation
3044 West Grand Blvd.
Detroit, Michigan 48202

Department of Health & Human Services
Social Security Administration
304 W. Michigan
Mt. Pleasant, MI 48858

Rhonda Tuby
Service Rep.
517-773-9924
07-08-87

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION

TOE 710

Form Approved
OMB No. 0960-0063

REQUEST FOR RECONSIDERATION

The information on this form is authorized by regulation (20 CFR 404.907 – 404.921 and 416.1407 – 416.1421). While your responses to these questions is voluntary, the Social Security Administration cannot reconsider the decision on this claim unless the information is furnished.

(Do not write in this space)

NAME OF CLAIMANT	NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON *(If different from claimant.)*
Alvin C. Schmidt	
SOCIAL SECURITY CLAIM NUMBER	SUPPLEMENTAL SECURITY INCOME CLAIM NUMBER
383 30 6301 HA	

SPOUSE'S NAME AND SOCIAL SECURITY NUMBER *(Complete ONLY in Supplemental Security Income Case)*

CLAIM FOR *(Specify type, e.g., retirement, disability, hospital insurance, supplemental security income, etc.)*

MP 12/30/82

I do not agree with the determination made on the above claim and request reconsideration. My reasons are:

I believe I've paid in the maximum for 17 years + my benefit should be higher.
I would like to have the computation checked for accuracy and explained to me.

NOTE: If the notice of the determination on your claim is dated more than 65 days ago, include your reason for not making this request earlier. Include the date on which you received the notice of the determination.

I am submitting the following additional evidence *(If none, write "None,")*:

None.

SUPPLEMENTAL SECURITY INCOME RECONSIDERATION ONLY *(see back of this form)*

"I want to appeal your decision about my claim for supplemental security income. I've read the back of this form about the three ways to appeal. I've checked the box below."

☐ Case Review ☐ Informal Conference ☐ Formal Conference

Signature *(First name, middle initial, last name) (Write in ink)*

SIGN HERE ➧ Alvin C. Schmidt

Date *(Month, day, year)* 12/30/82

Telephone Number 644-2020

Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*
1346 DENVER RD

City and State	ZIP Code	Enter Name of County (if any) in which you now live
Weidman Mi.	48893	Isabella.

Witnesses are required ONLY if this request has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person requesting reconsideration must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address *(Number and street, City, State, ZIP Code)*	Address *(Number and street, City, State, ZIP Code)*

FOR SOCIAL SECURITY OFFICE USE ONLY

SOCIAL SECURITY OFFICE ADDRESS

THIS WAS TURNED DOWN

SOCIAL SECURITY BENEFIT INFORMATION

From: Great Lakes Program Service Center
Chicago, Illinois 60661

Date JUNE 28, 1995

Your Claim Number
383-30-6301 A

ALVIN C SCHMIDT
1346 W DENVER RD
WEIDMAN MI 48893-9768

Reason for action
ATTAINMENT OF AGE 65

Type of action
DISAB TO RETIREMENT

☐ As a result of the action being taken, benefit payments have been refigured as shown below. The amount shown in column 4, represents all benefits due on this claim through the month shown in column 5. You will then receive the amount shown in column 3 regularly each month.

☐ Benefit payments have been discontinued with the month shown in column 2 for the reason shown above.

☒ We have determined that you are entitled to the benefits shown below.

☐ As shown below, the next payment will be sent to you shortly. You will then receive the amount shown in column 3 regularly each month.

1. Additional payment information	2. Effective month	3. Regular monthly payment	4. Net amount of next payment	5. Next payme pay amt. d through m
YOUR BENEFIT WILL CONTINUE IN THE SAME AMOUNT IMPORTANT**READ ENCLOSED BOOKLET SSA-05-10077 CAREFULLY.	07/95			

Note to Terminated Beneficiary:
Earnings for the entire year both before and after your benefits were stopped must be considered in determining whether you earned more than the allowable yearly limit. Please read the rest of this notice for additional information on work and reporting.

Note to Terminated Mother/Father Beneficiary:
You are not entitled to widow(er)'s benefits because you are not age 60 or disabled and age 50.

Note to Terminated Wife Beneficiary:
You are not entitled to retirement benefits because you are not yet age 62.

Note to Student Beneficiary:
If your benefits are being stopped because we did not receive your student report and you filed a repo with your school more than two weeks ago, please contact any Social Security office for assistance. DO NOT CONTACT YOUR SCHOOL IF YOU HAVE ALREADY FILED A REPORT.

If you have not completed your report you should do so IMMEDIATELY and take it to your school. If you need a report form, ask for one at any Social Security office. If you have taken the form to your school within the last two weeks, you needn't contact the Social Security office unless your next benef check does not arrive on time.

C82306

Social Security Award Certificate

From: Department of Health and Human Services
Social Security Administration

Date NOV. 9, 1982

ALVIN C SCHMIDT
1346 W DENVER
WEIDMAN MI 48893

Claim Number: 383-30-6301 HA

THIS WHAT I WAS PAID

Type of Benefit	Date of Entitlement	Monthly Benefit
DISABILITY	4/82	$ 540.4
	6/82	$ 580.3

THE AMOUNT OF YOUR FIRST PAYMENT IS $ 3980.80.

YOUR MONTHLY BENEFIT RATE HAS BEEN INCREASED BEGINNING 6/82 BECAUSE OF AMENDMENTS TO THE SOCIAL SECURITY ACT.

SHORTLY AFTER 11/04/82, YOU WILL RECEIVE YOUR FIRST PAYMENT WHICH WILL INCLUDE ALL BENEFITS DUE YOU THROUGH 10/82. A PAYMENT FOR $580.00 WILL BE SENT ON OR ABOUT 12/03/82. AFTER THAT, A PAYMENT F $580.00 WILL BE SENT EACH MONTH.

BECAUSE OF A CHANGE IN THE LAW, YOUR REGULAR PAYMENT WILL BE ROUNDE DOWN TO THE DOLLAR EVEN THOUGH YOUR MONTHLY BENEFIT OF RECORD MAY B IN DOLLARS AND CENTS.

SERVICE IN THE ARMED FORCES AFTER SEPTEMBER 15, 1940, HAS BEEN COUNTED. HOWEVER, IF ANOTHER KIND OF FEDERAL BENEFIT (EXCEPT ONE FROM THE VETERANS ADMINISTRATION) IS PAYABLE BASED ON MILITARY SERVICE BEFORE 1957, PLEASE CONTACT ANY SOCIAL SECURITY OFFICE PROMPTLY.

YOUR CLAIM WILL BE REVIEWED FROM TIME TO TIME TO SEE IF YOU ARE STI ELIGIBLE FOR BENEFITS BASED ON DISABILITY OR BLINDNESS. WHEN YOUR CLAIM IS REVIEWED, YOU WILL BE CONTACTED IF THERE IS ANY QUESTION A TO WHETHER YOUR ELIGIBILITY CONTINUES.

SINCE YOUR CONDITION MAY IMPROVE, WE HAVE SCHEDULED A REVIEW FOR 10/85. AT THAT TIME, YOU WILL BE CONTACTED IF THERE IS ANY QUESTIO AS TO WHETHER YOUR CONDITION REMAINS SEVERE. ALSO, A REVIEW OF YOU CLAIM MAY BE NECESSARY IF YOU RETURN TO WORK.

IF WE DO GET IN TOUCH WITH YOU, WE MAY ASK YOU TO GIVE US MORE INFORMATION OR TO TAKE A MEDICAL EXAMINATION. IF WE FIND YOU ARE

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